Congress of the United States
U.S. House of Representatives
COMMITTEE ON WAYS AND MEANS
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September 4, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health & Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Verma:

We applaud the Administration for the recent work to cut red tape through the Patients over Paperwork initiative, including through finalizing policies to reduce regulatory burden in the Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System Final Rule. Similarly, the Ways and Means Committee has undertaken the Medicare Red Tape Relief Project, an initiative aimed at identifying opportunities to reduce legislative and regulatory burdens on Medicare providers while improving the efficiency and quality of the Medicare program for seniors and individuals with disabilities. We write today in support of these efforts and encourage the Administration to work with stakeholders and Congress to continue to remove regulatory barriers that get in the way of patient care in future rulemaking for hospital providers. Specifically, we ask that you consider additional regulatory relief involving hospital conditions of participation, co-location of providers, hospital quality star ratings, and the Meaningful Measures Initiative.

There is a big opportunity to improve patient care by alleviating hospitals from administrative burden that is driving up the cost of health care. It is noteworthy that burden reduction policies in the IPPS and LTCH Final Rule would save 2 million hours of burden and generate at least $75 million in savings to hospitals. In fact, when accounting for the burden reduction policies in the IPPS and LTCH Final Rule combined with those burden reduction policies in the Outpatient Prospective Payment System (OPPS) Proposed Rule, hospitals are estimated to save about 3.5 million hours in administrative work, which amounts to nearly 1,000 hours in time saved per hospital.

Conditions of Participation

According to a survey of nearly 200 hospitals across the country, the single biggest administrative cost to hospitals and certain post-acute care settings are the requirements

associated with the conditions of participation (CoPs).[1] As part of the Ways and Means Committee's Medicare Red Tape Relief Project, we heard from dozens of hospitals about extensive burdens associated with hospital CoPs. Hospitals support the spirit of many of the hospital CoPs, but often find that the implementation of CoPs is needlessly burdensome and does not support the health, safety, and quality of patient care. The end result is that many CoPs become a documentation exercise or a check-the-box requirement that does not promote patient care, and instead simply takes health care practitioners away from the patient bedside. Therefore, we recommend that CMS work with hospitals to evaluate the implementation of various CoPs (e.g. labor-intensive documentation requirements) for the purpose of amending, streamlining, or eliminating individual CoPs consistent with a common-sense approach. The duplication of efforts associated with validation surveys is one example of adding unnecessary costs to the health care system. We would like CMS to consider a solution to eliminate this duplication by incorporating the oversight and validation into the initial survey process. More broadly, when reforming CoPs, CMS should consider a similar approach to that taken to improve quality measurement in CMS' Meaningful Measures Initiative by establishing principles for what kind of standards should be retained that will truly make patient care safer, and eliminate or revise standards that do not achieve that goal.

Co-Location

In addition, during the Committee's Red Tape Roundtables, we heard from multiple providers on the issue of "co-location," arrangements by which providers often share medical space with other providers. Visiting specialists provide a crucial service in rural communities, providing access to critical specialists that otherwise would not be available. Allowing visiting specialists to utilize rural hospitals and provider-based clinics is a helpful way to increase access to care. Unfortunately, there are burdensome requirements whereby visiting physicians may practice in a hospital or clinic only if that facility provides them with a separate entrance, waiting and registration areas, permanent walls, and a distinct suite designation. As a result, many clinicians are prohibited from co-locating in the hospital setting. This limits access to specialists willing to travel to rural areas to see patients since there is no alternative space set up for medical care in these rural communities. To address these concerns, we urge CMS to release flexible guidelines regarding co-location arrangements that will allow greater access to care and enhance coordinated care for patients, such as allowing visiting specialists to provide care in what is otherwise hospital space or allowing common waiting rooms and passageways that permit patients to easily access different providers.

Hospital Quality Star Ratings

We are pleased to learn that CMS will seek feedback from a Technical Expert Panel (TEP) with outside experts to address concerns related to the accuracy and reliability of what is conveyed to patients in the hospital quality star ratings on Hospital Compare. We hope the TEP will take a broad conceptual approach and also offer expert statistical guidance on how to update the methodology for calculating the star ratings, such as re-evaluating the current approach to measure group weightings and evaluating stakeholder concerns over the measures included in the

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[1] American Hospital Association. Regulatory Overload Report: Assessing the Regulatory Burden on Health Systems, Hospitals and Post-Acute Care Providers, October 2017. Accessed on July 19, 2018 at https://www.aha.org/system/files/2018-02/regulatory-overload-report.pdf

overall star rating. If that exceeds the scope of the current TEP, we urge CMS to convene a separate TEP to consider a broader overhaul of the hospital quality star ratings on Hospital Compare.

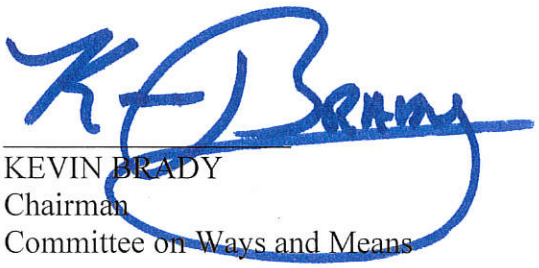
An example of what we would like to see CMS do in both the short and long term is to assess how to improve the validity and risk adjustment of measurement to ensure that star ratings are accurate and useful to hospital consumers. This would include assessing the effect of sociodemographic adjustment for outcome measures and exploring alternative approaches to an overall star rating. Analysis shows there are biases against certain classes of hospitals and patients with certain socioeconomic status characteristics or geographic location (e.g. rural vs. urban). Much of this seems to be a result of the current risk adjustment mechanism.

Meaningful Measures Initiative

Similarly, we applaud CMS' Meaningful Measures Initiative, which aims to reduce and prioritize quality measures across the Agency's quality reporting and pay-for-performance programs. The Committee has long advocated for and advanced quality improvement efforts in the Medicare program and welcomes CMS' efforts to improve and streamline quality measures, reduce regulatory burden, and promote innovation. We appreciate CMS' efforts to eliminate duplication across hospital quality reporting programs. We urge CMS to continue these efforts and conduct a more comprehensive measure review project to evaluate all current measures to determine which are most effective in tying payment to patient outcomes and which should be removed. We encourage CMS to take additional steps to streamline quality reporting while eliminating measures that are not tied to patient outcomes and that create unnecessary burden for providers.

Thank you again for all your efforts to reduce burdens for Medicare providers and improve the program for beneficiaries. We look forward to continuing to work with the Administration on additional opportunities to improve patient care and reduce health care costs by eliminating regulations that distract providers from patient care, drive up costs, hinder access, and get in the way of coordinated care.

Sincerely,



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Committee on Ways and Means

PETER J. ROSKAM
Chairman
Subcommittee on Health
Committee on Ways and Means

CC: The Honorable Mick Mulvaney
Director
White House Office of Management & Budget

CC: The Honorable Alex Azar, Secretary
U.S. Department of Health and Human Services